Defending Liberty
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AMERICAN BAR ASSOCIATION

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Dear Representative:

We understand that in the near future the House is expected to consider H.R. 534, legislation to pre-empt substantial portions of the state medical liability laws. On behalf of the American Bar Association, I urge you to vote against passage of H.R. 534. The ABA opposes H.R. 534 because it would interfere with the traditional state regulation of medical liability laws and restrict the rights of injured patients to be compensated for their injuries.

For over 200 years, the authority to promulgate medical liability laws has rested with the states. This system, which allows each state autonomy to regulate the resolution of medical liability actions within its borders, is a hallmark of our American justice system. Because of the role they have played, the states are the repositories of experience and expertise in these matters. If enacted, H.R. 534 would pre-empt the rights of the states to continue to administer the medical liability laws.

Currently, states have the opportunity to enact and amend their tort laws, and the system functions well. Congress should not substitute its judgment for the systems that have thoughtfully evolved in each state over time. To do so would limit the ability of a patient who has been injured by medical malpractice to receive the compensation he or she deserves.

The ABA is especially concerned about the provisions in H.R. 534 that would place a cap on pain and suffering awards in states that have no such cap. The ABA opposes caps on pain and suffering awards which ultimately harms those who have been most severely injured. Instead, the courts should make greater use of their powers to set aside verdicts involving pain and suffering awards that are disproportionate to community expectations.

Medical professional liability expenditures account for less than two percent of national health care expenditures. Provisions contained in H.R. 534 to cap non-economic damages would not eliminate the less than two percent of health care costs attributable to medical professional liability since very few people are the subject of such caps. Any savings in the cost of health care would be a small fraction of the less than two percent figure.

There is no question that malpractice premiums have risen. The question is why. There is no evidence that the legal system has caused the spike in rates. And there is no evidence that caps will be effective in reversing the trend. In fact, not even data provided by the AMA in June 2004 supports the idea that placing caps on damages can avert a medical malpractice crisis in a particular state, or that states that fail to enact caps are certain to have a crisis. At that time, eight states that were listed by the AMA as “in crisis” (Florida, Massachusetts, Mississippi, Missouri, Nevada, Ohio, Texas, and West Virginia) had already enacted caps on non-economic damage awards. Fourteen other states that had such caps were, according to the AMA, “showing problem signs,” and just six of the states that had enacted caps were considered by the AMA to not be “in crisis” or “showing

problem signs." This follows a June 2003 report by Weiss Ratings, Inc., which found that caps on non-economic damages have failed to prevent sharp increases in medical malpractice insurance premiums, even though insurers enjoyed a slowdown in their payouts.[1]

A July 2003 General Accounting Office study of the causes of malpractice insurance increases found that, while malpractice awards have contributed to increased premiums, "a lack of comprehensive data at the national and state levels on insurers' medical malpractice claims and the associated losses prevented us from fully analyzing the composition and causes of those losses."[2] In fact, relevant studies have since been released that analyze and challenge the alleged link between the tort liability system and malpractice premiums. Two notable studies suggest that the issue is much more complex.

One such study, in Texas, found no evidence to support a link between rising malpractice premiums in Texas and the frequency of claims and size of payouts, despite Texas voters having passed a constitutional amendment in 2003 that sharply restricted non-economic damages in medical malpractice lawsuits. The Texas study was developed by researchers at three major universities. An examination of the comprehensive database of closed malpractice claims maintained by the Texas Department of Insurance found that the number of paid malpractice claims (adjusted for population growth) was roughly constant between 1991 and 2002, the frequency of such claims actually declined, the frequency of individual jury awards in malpractice cases declined, and the percentage of claimant verdicts showed no upward trend.[3]

Similarly, a study by the Kaiser Family Foundation showed that capping damages in medical malpractice cases does not reduce doctors' exposure to malpractice claims. The Kaiser Family Foundation report on medical malpractice was released on May 27, 2005. The report provides trend data for malpractice claims. It shows that the total dollars in physician medical malpractice claim payments remained relatively constant during the period from 1991 to 2003 (13,687 in 1991, compared with 15,287 in 2003). The average number of malpractice claims per physician declined relatively steadily over the period.

The American Bar Association analyzed the Kaiser Family Foundation report's new state malpractice data (available at http://www.statehealthfacts.org/r/malpractice.cfm) on the number of paid claims per 1,000 physicians in each state in 2003, the latest year for which data is available. The chart attached as Appendix "A" lists the number of claims per 1,000 active, non-federal physicians and shows whether the state had caps on noneconomic or total damage caps in 2003. This data shows the number of paid claims per 1,000 active non-federal physicians is not related to whether a state has caps on damages or not. For example, the average claims for 1,000 physicians ranged from a high of 30.5 in Indiana, which had damage caps in 2003, to a low of 5 in Alabama, which did not have caps on non-economic or total damage caps in 2003.

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[1] Weiss Ratings, Inc., *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage*, June 2, 2003.

[2] General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June 2003); General Accounting Office, *Medical Malpractice: Implications for Rising Premiums on Access to Health Care*, August 2003, p. 9.

[3] Bernard Black, et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas*, 1988-2002.

It is obvious that those affected by caps on damages are the patients who have been most severely injured by the negligence of others. No one has stated that their pain and suffering injuries are not real or severe. These patients should not be told that, due to an arbitrary limit, they will be deprived of the compensation they need to carry on. Yet H.R. 534, if enacted, would result in the most seriously injured persons who are most in need of recompense receiving less than adequate compensation.

On July 14, 2005, the Wisconsin Supreme Court, in a quite lengthy and well-thought-out opinion, found caps in malpractice cases to be unconstitutional. *Ferdon v. Wisconsin Patients Compensation Fund, et al*., Case No. 2003AP988. As part of its analysis of the issues, the Court noted that the cap put in place ($350,000) was apparently based on the assumption that the cap would help to limit the increasing cost and possible diminishing availability of health care, although the immediate objective was apparently to ensure the availability of sufficient liability insurance at a reasonable cost. *Slip Op*. at 45. The Court found no rational relationship between "the classification of victims in the $350,000 cap on non-economic damages" and the equally desirous objective of compensating victims fairly, both those who suffer non-economic damages above and below the cap. *Slip Op*. at p. 50. The Court found that the cap is "unreasonable and unnecessary because it is not rationally related to the legislative objective of lowering medical malpractice insurance premiums" and it creates an undue hardship on those whose non-economic damages exceed the cap and is thus arbitrary. *Slip Op*. at pp. 49, 53. The Court came to its conclusion after reviewing an analysis of studies done within the state by the Wisconsin Commissioner of Insurance and of studies outside the state. *Slip Op*. at pp. 59-66.

We urge you to vote no on H.R. 534.

Sincerely,

Miles J. Zaremski
Chair, ABA Standing Committee on Medical Professional Liability

APPENDIX A

# Capping Damages Does Not Reduce Doctors' Exposure to Malpractice Claims

The Kaiser Family Foundation recently issued a new report containing state-specific data for 2003 on medical malpractice claim payments. As has been reported, the study provides data showing that, while the total dollars in paid physician medical malpractice claims more than doubled from $2.1 billion in 1991 to $4.5 billion in 2003, the number of malpractice claim payments nationwide remained relatively constant during that period (13,687 in 1991, compared with 15,287 in 2003). Also, the report noted that, since the number of practicing physicians increased during this period, the average number of malpractice claims per physician declined relatively steadily over the period, from 25 in 1991 to 19 per 1,000 non-federal physicians in 2003.[4]

The American Bar Association has analyzed the information in the Kaiser study, including the report's new state malpractice data (available at http://www.statehealthfacts.org/r/malpractice.cfm) on the number of paid claims per 1,000 physicians in each state in 2003, the latest year for which data are available. The attached chart lists the number of claims per 1,000 active, non-federal physicians and shows whether the state had caps on noneconomic or total damage caps in 2003. **This data shows the number of paid claims per 1,000 active non-federal physicians is not related to whether a state has caps on damages or not**. For example, the average claims for 1,000 physicians ranged from 30.5 in Indiana to 5 in Alabama. Indiana had total damage caps in 2003. Alabama did not have caps on noneconomic or total damage caps in 2003.

Developed by the American Bar Association with the assistance of the Standing Committee on Medical Professional Liability. For questions, please contact Lillian Gaskin, Senior Legislative Counsel at 202-662-1768 or gaskinl@staff.abanet.org.

[4] The report was prepared for the Foundation by Peter P. Budetti of the University of Oklahoma Health Sciences Center and Teresa M. Waters of the University of Tennessee Health Science Center. The data are based on an analysis of 2003 claims data in the federal National Practitioner Data Bank, where federal law requires that paid claims be reported.

| State | Number of Paid Claims Per 1,000 Active, Non-Federal Physicians | States with Noneconomic and/or Total Damage Caps in 2003 | States without Noneconomic and/or Total Damage Caps in 2003 |
|---|---|---|---|
| Alabama | 5 | | X |
| Minnesota | 7 | | X |
| Wisconsin | 8 | X | |
| Maine | 9 | X | |
| Massachusetts | 9 | X | |
| Virginia | 9 | X | |
| North Carolina | 10 | | X |
| Tennessee | 10 | | X |
| District of Columbia | 11 | | X |
| Vermont | 11 | | X |
| Arkansas | 12 | | X |
| Oregon | 12 | | X |
| Washington | 12 | | X |
| Colorado | 13 | X | |
| Hawaii | 13 | X | |
| Idaho | 13 | X | |
| Maryland | 13 | X | |
| New Hampshire | 13 | | X |
| Alaska | 14 | X | |
| California | 14 | X | |
| Illinois | 14 | | X |
| Missouri | 15 | X | |
| Kansas | 16 | X | |
| New Mexico | 16 | X | |
| Connecticut | 17 | | X |
| Georgia | 17 | | X |
| South Carolina | 17 | | X |
| Iowa | 18 | | X |
| Ohio | 18 | | X |
| Oklahoma | 18 | | X |
| Rhode Island | 18 | | X |
| Utah | 18 | X | |
| Michigan | 20 | X | |
| Mississippi | 20 | X | |
| Nebraska | 20 | X | |
| New Jersey | 20 | | X |
| North Dakota | 21 | | X |
| Texas | 22 | | X |
| Kentucky | 23 | | X |
| Louisiana | 23 | X | |
| Nevada | 23 | X | |
| New York | 23 | | X |
| South Dakota | 23 | X | |
| West Virginia | 23 | X | |
| Arizona | 24 | | X |
| Wyoming | 25 | | X |
| Montana | 27 | X | |
| Delaware | 28 | | X |
| Florida | 28 | X | |
| Indiana | 30 | X | |
| Pennsylvania | 30 | | X |